

## Marketplace

# 85% of Ont. nursing homes break the law repeatedly with almost no consequences, data analysis shows

Hidden camera reveals staff hitting, yelling at resident in nursing home with repeat abuse offenses

[Katie Pedersen](#), [Melissa Mancini](#), [David Common](#), [William Wolfe-Wylie](#) · CBC News ·

Posted: Oct 23, 2020 4:00 AM ET | Last Updated: October 23, 2020



Von shares a moment with his mother, Kostadinka. She lived at Craiglee nursing home where she was met with physical abuse from staff members. Von managed to have her transferred to a different long-term care home, where she died in 2019. (Submitted by Von and Mary)

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***Warning: This story contains images that some people may find disturbing.***

When Von took his mother out of his home and placed her in Craiglee Nursing Home in Scarborough, Ont., he and his partner, Mary, thought they were doing what was best for her.

But instead of loving care, Von's mother, Kostadinka, was met with physical and emotional abuse at the hands of at least four different care workers, caught on a camera they had hidden in her room.

"It was like a horror film," said Mary. "I will never be able to unsee those things."

What they didn't know at the time was that the home had a long and repeated history of staff physically abusing the residents. They didn't know — but the government did.

***WATCH | Son says he 'couldn't believe' what hidden camera caught workers doing to his mother:***



**Nursing home staff 'abuse, torture' 82-year-old on hidden camera**

9 months ago | 5:00

This man installed a hidden camera in his mother's room at a long-term care home in Scarborough, Ont. The videos showed different employees physically and verbally abusing the 82-year-old. She was "holding onto the bed rails for dear life," her son said. 5:00

A data analysis of the most serious breaches of Ontario's long-term care home safety legislation reveals that six in seven care homes are repeat offenders, and there are virtually no consequences for homes that break that law repeatedly.

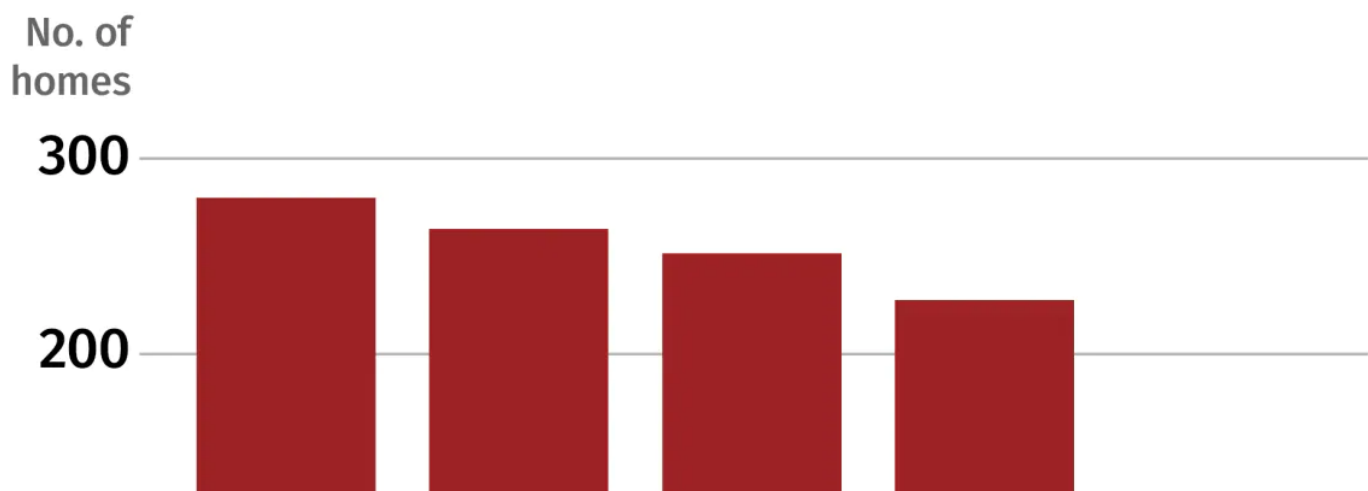
CBC *Marketplace* reviewed 10,000 inspection reports and found over 30,000 "written notices," or violations of the [Long-Term Care Homes Act and Regulations](#) (LTCHA), between 2015 and 2019 inclusive. The LTCHA sets out minimum safety standards that every care home in Ontario must meet.

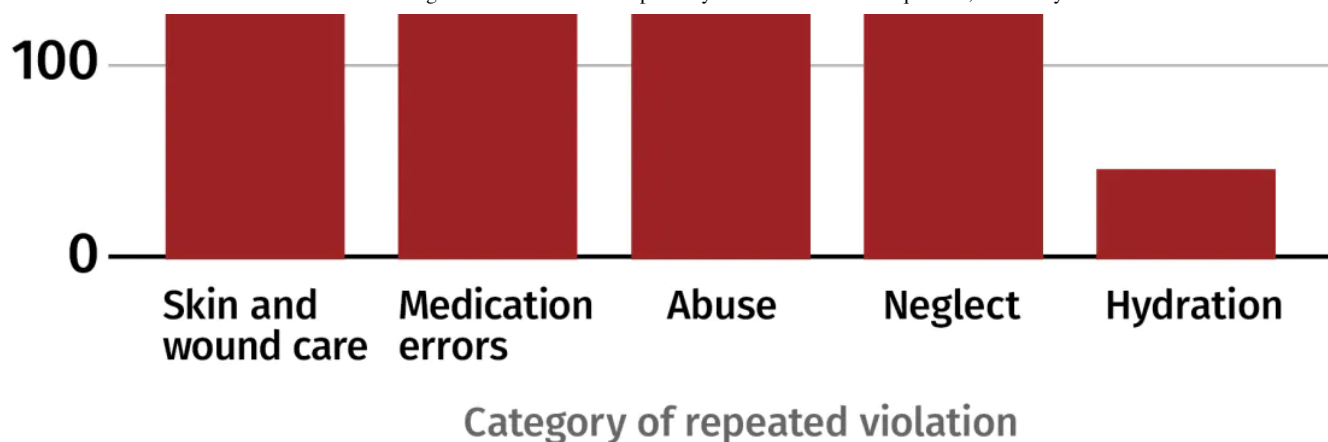
*Marketplace* isolated 21 violation codes for some of the most serious or dangerous offences, including abuse, inadequate infection control, unsafe medication storage, inadequate hydration, and poor skin and wound care, among others. The analysis found that of the 632 homes in the Ontario database, 538 — or 85 per cent — were repeat offenders.

- [Top 30 Ontario long-term care homes with most reported violations](#)

Jane Meadus, a lawyer with the Advocacy Centre for the Elderly, said the high number of repeated incidents shows that non-compliance with the law has been normalized within care homes.

## Repeat offenders of the Long-Term Care Homes Act by type of offence 2015-2019





#### CBC NEWS

Meadus said lack of proper care can lead to bedsores, for example, which residents can die from.

"If that person was in your home, if you were caring for your parent and they had these giant bedsores, you would likely be charged criminally for that," she said.

"A home has never been charged criminally for what I think is criminal behaviour."

### 'We couldn't believe what we saw'

Craiglee Nursing Home was one of at least 248 homes that have been written up twice or more for abuse and 101 homes that have repeatedly failed to report abuse.

Craiglee also had repeated violations for neglect, lack of infection control, medication errors, and poor skin and wound care.

Unaware of the home's history, Von and Mary entrusted the home with Kostadinka's care in 2017 when her needs became more than a two person job.

*Marketplace* has agreed to tell their story using only their first names because they fear retaliation against them and their business.

Kostadinka, pictured here at 80 years old, lived at Craiglee Nursing Home for two years. While there, she encountered physical and verbal abuse from the workers who were entrusted with her care. (Submitted by Von and Mary)

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When they saw Kostadinka's health declining, the partners put a camera in Von's mother's room as a precautionary measure in April of 2019, not expecting to see any problems. The camera ran for weeks before they were able to see what it had captured.

"We couldn't believe what we saw," said Von. "Abuse, torture, her holding onto the bed rails for dear life."

The videos showed several employees yanking on Kostadinka's arms, swatting her hands, or rubbing spilled food in her face. Although the videos have no audio, employees could be seen yelling at Kostadinka as she lay in bed, unable to move without their help.

## More residents abused after videos submitted to ministry

After Von and Mary saw the extent of the abuse, they decided to call police. A personal support worker was arrested and ultimately entered into a three-year peace bond, agreeing not to work with vulnerable people. Kostadinka was moved to a different care home, where she died late last year.

The home would not agree to an interview with CBC. But Candace Chartier with Southbridge Care Homes, Craiglee's parent company, offered a statement.

"We strongly condemn the actions of the individuals involved," Chartier said in the statement. She said the home investigated Kostadinka's abuse in July of 2019 and reported it to police, after which one staff member was criminally charged and "several others were terminated."

Candace Chartier, the chief seniors' advocate and strategic partnerships officer at Southbridge Care Homes — the parent company of Hope Street Terrace — says she 'strongly condemns' the abuse that went on in the home. (CBC)

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Chartier said they also "re-educated all staff in the home on [the] zero-tolerance policy" for abuse, and enhanced their training.

The Ontario [Ministry of Long-Term Care's inspection report](#) from September 2019 that detailed Kostadinka's abuse revealed a lack of staff training on abuse policies. Yet, four months later, another [report](#) revealed 9.2 per cent of actively working staff had still not completed the mandatory training. Six months later, another incident of staff-to-resident abuse was

documented in yet another [report](#). There have also been incidents of financial abuse and resident-on-resident abuse.

Von said he was "disgusted" to learn that even after he sent video evidence of his mother's abuse to the ministry, there have been more written notices at Craiglee for abuse.

"What does it take?" said Von. "We brought it to the ministry's attention, brought it to the director of care's attention, we brought it to the authorities, to the police."

"Everything my mom endured was all for naught."

A still frame from hidden camera footage shows a personal support worker aggressively handling a resident of an Ontario nursing home as she lies in bed, unable to move without her help. (Submitted by Von and Mary)

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## Family fights for criminal charges for nursing homes

While physical abuse is fairly clear, neglect can take on many forms such as lack of hydration or failure to provide baths. Two hundred and twenty-six homes had repeat offences for failing to "ensure that residents are not neglected by the licensee or staff," but many more incidents were filed under different codes for specific acts of neglect, like improper skin and wound care — 278 homes had repeat offences.

Beverley Haines died in February of this year, only six weeks after she moved into Hope Street Terrace in Port Hope, Ont., because of large bedsores she sustained at the home. Sparky Johnson and Sherry Schernitzki, Haines's niece, are fighting to have the home's administration held criminally responsible for her death.

A sign depicting graphic images of Beverley Haines's bedsore rests against a stop sign beside Queen's Park in Toronto. Sparky Johnson brought the sign to a rally for long-term care outside the Ontario Legislature, but was asked to take it off the property because it was too graphic. (Katie Pedersen/CBC)

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The partners, now separated, said that on the day Haines moved from a hospital into the home in January 2020, the staff identified a "hot spot," or patch of red skin. These spots must be monitored or treated so they don't get worse, and the pair left with confidence that it would be taken care of.

But the pair weren't informed that the hot spot had become an open bedsore until 23 days later. At that point, it had already progressed to a wound the size of a saucer with bone exposed.

"If the treatment had started when this bedsore was small, it should never ever have gotten to that," said Schernitzki.

"It's horrific. It's criminal," said Johnson.

***WATCH / 'How can this happen to a person?': Family seeks criminal charges for aunt's death:***



**Her aunt died weeks after moving into long-term care**

9 months ago | 2:52

Six weeks after Beverley Haines moved into an Ontario nursing home, she died of a large bedsore she sustained there. The facility had been written up twice before for lack of proper wound care. 2:52

The home had been written up for lack of proper wound care before. Reports from [2016](#) and [2018](#) both found the home was not following proper protocols for caring for "altered skin integrity."

Johnson called the ministry to report the bedsore, but was told an inspection would take some time. She made another call to police, and an investigation was launched.

She began documenting problems at the home, including multiple instances where Haines was left in bed all day, lying on her back on the open bedsore.

Sherry Schernitzki, left, and Sparky Johnson, right, want criminal charges laid after Schernitzki's aunt, Beverley Haines, died from her bedsore at a Port Hope, Ont., long-term care facility. They are pictured here in a memorial garden where they plan to lay a plaque for Haines. (Katie Pedersen/CBC)

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The ministry published a report [in June](#) finding the home's records didn't show proper monitoring of the bedsore, which should have included repositioning every one to two

hours to ensure she wasn't lying on the wound.

"It was an excellent report, but what happens now? Who follows up?" said Schernitzki. "There are no consequences."

By the time that report was released, it was too late to address the issues within it. Haines died on Feb. 29. The family says they were told by the investigating coroner that she died of sepsis from the bedsore.

The two felt strongly that the home was criminally negligent, but the police investigation was closed after Haines died without charges being laid. They continue to fight, filing a complaint with the Office of the Independent Police Review Director, a civilian body that oversees complaints about police in Ontario. The case has since been reopened.

Haines, pictured here at 75, was an accountant throughout her life who enjoyed painting and spending time at her cottage in Harcourt, Ont., about 100 kilometres north of Peterborough. She died at Hope Street Terrace in Port Hope at 85. (Submitted by Sherry Schernitzki)

The home said it is "deeply saddened about the passing of this resident" and that its "utmost priorities are the safety and well-being of our residents."

## 'No tolerance' for abuse, says minister

Most homes have not faced any punishment for failure to comply with the law. Only two Ontario homes have been shut down in the last decade for repeatedly failing to meet safety standards. Other sanctions available to the ministry appear to be ineffective in preventing future repeat offences.

*Marketplace* host David Common called into a press conference with Minister of Long-Term Care Merrilee Fullerton earlier this week to ask her to speak to the fact that despite orders that are available to inspectors, homes still appear to make the same behaviours repeatedly.

"There's no tolerance whatsoever for negligence or abuse," she said, noting that she feels her government is prioritizing serious offences in their inspections.

"They must be dealt with in a fulsome way."

## 'No consequence,' says former inspector

But a former inspector said that in her experience, issues weren't dealt with in a fulsome way, and that's part of the reason why she left the job.

- **EXCLUSIVE** [Comprehensive nursing home inspections caught up to 5 times more violations. Why did Ontario cut them?](#)
- **CBC INVESTIGATES** [Infection control oversight lacking at Ontario seniors' homes as inspections dwindled](#)

Rebecca de Witte, who worked as an inspector for three years up until March of 2017, said she felt identifying problems in the homes wasn't helping get rid of them.

"When you arrive, everything looks really good. And then as time goes by, old habits crop up again," she said.

She said she would often inspect a home and find the same problems that she saw when she had last been there.

"There is no consequence if the homes completely ignore everything you find," she said.

Rebecca de Witte used to inspect long-term care homes. She said she often found the same problems over and over again in the homes, and that there were no consequences when homes ignored the findings of her reports. (CBC)

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## Federal government proposing new rules

In its speech from the throne in October, the federal government promised to work with the provinces and territories to set out a national standard of care for long-term care, and would amend the Criminal Code in order to "explicitly penalize those who neglect seniors under their care."

For de Witte, governments need to focus on the big picture instead of what she calls "band-aid" fixes.

- **MARKETPLACE** [Hidden-camera footage reveals overstretched nursing home staff struggling to care for residents](#)

"Funding for air conditioning isn't going to help long-term care, but changing the buildings will," she said. "Pandemic pay isn't going to help long-term care, but changing the funding model will."

Meadus wants to see criminal charges for negligence and monetary penalties for repeat offenders.

"If the home is not able to provide safe care they shouldn't be in business," she said.

*Click [here](#) to see the methodology of our investigation and statements from those featured in our story.*



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